

I-Resolutions Inc.

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

DATE OF REVIEW:

Jul/07/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

300 Units Botox x 1 injection

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic Surgeon and Spinal Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Determination letters, 03/19/09, 04/02/09

D.O., 03/25/09, 03/20/09, 06/24/09, 03/16/09, 10/15/08, 10/09/08, 04/10/08, 06/11/09, 05/20/09, 05/18/09, 05/12/09, 05/06/09, 04/21/09, 04/15/09, 04/14/09, 04/08/09, 03/31/09, 03/06/09, 02/17/09, 01/20/09, 12/19/08, 12/15/08, 012/10/08, 07/25/08, 11/03/08, 10/14/08, 10/09/08, 09/25/08

Sacroiliac joint injection, 04/21/09, 04/14/09, 03/06/09, 12/15/08, 12/10/08

Drug screen, 03/30/08, 06/11/09

ODG/TWC

Face sheet, 06/11/09, 10/09/08

Functional Capacity Evaluation, 01/17/08, 11/06/07

, 09/24/97

MRI scan of lumbar spine

M.D., 01/10/01

Prescription, 11/19/07

Pain Management, 08/14/00, 03/31/00

D.C., undated

M.D., 06/15/00

D.O., 09/14/99, 04/11/00, 02/06/95

Lumbar myelogram, 10/12/93

M.D., 02/20/94

M.D., 02/04/94

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker with complaints of back pain, radiating leg pain, numbness and weakness. His physical examinations have revealed relatively normal range of motion of his lumbar spine. The neurologic examinations performed within the records do not show any neurological deficit. The MRI scan does not show any significant findings other than some facet arthropathy. There is minimal evidence of degeneration with some annular bulging at L1/L2, L2/L3, L3/L4, and L4/L5. There is a small right central foraminal disc protrusion that potentially impinges upon the right L4 root, but this does not correspond with the patient's complaints. He has facet arthrosis at L3/L4 and L4/L5 and significant arthrosis at L5/S1 on the left. None of this corresponds with his complaints of radicular pain below the knee but might have a component of being involved with his back pain. He has been on a number of medications including Lortab, Xanax, and oral morphine, the indications of which cannot be gleaned from the record due to the absence of significant pathology. There is a request for an electric wheelchair, the basis of which is impossible to determine, given the lack of objective findings both on the imaging studies and the physical examination. There is also a request for a home therapeutic weight and exercise machine. Current request is for Botox injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The reviewer has reviewed the 2009 Guidelines for the use of Botox. The recommendation for Botox in this patient is difficult to support given the absence of any significant pathology that would be an indication for this particular procedure. While there have been some favorable initial responses in small trials giving promising results in small groups of selective back pain patients, this particular patient would not be characterized as a "select" patient according to the records provided for this review. There is currently "insufficient scientific evidence of the effectiveness of botulism toxin in the treatment of back pain" to support FDA approval at this time. The rates of relief from botulism toxin injection appear to be similar to that with placebo. At this time "botulism toxin injections are not supported by convincing consistent evidence of benefit from randomized clinical trials." It is this reviewer's opinion that this injured worker does not have significant documented pathology warranting the use of botulism toxin. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for 300 Units Botox x 1 injection.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)